Compiled Report from the Continuum Subgroups

On August 18, 2005, a group of State DHR, various county DHR and provider staff met to plan for the development of continuums for placement services for children for Alabama. The group was divided into 4 smaller groups to discuss issues and make suggestions in the areas of defining continuum (including setting goals, types of continuums, exemptions and outliers), barriers (including roles of DHR and providers), costs (including incentives, shared risks, and fiscal agents), and collaboration issues. The following is a compilation of the work done in each committee or subgroup. After meeting with CWLA, the subgroups will meet again, and other stakeholders will be brought into the process.

Work from the Definition Subgroup:

Continuum of Care – A dynamic process which focuses on achieving the outcome of successful permanency for children in a family setting. It has the flexibility to design services which are family driven and youth focused and individualized for children and families, as well as the ability to customize the delivery of services in the least restrictive manner.

Partnerships and collaborations insure flexibility.

If there are any further revisions that you would suggest before this is submitted on the 9th, please email them to me today or tomorrow.

Definitional Issues/Questions to be addressed

- Does the continuum need to be stratified with multiple entry levels? For example, Tennessee's continuum has Level 3 (most intensive) referrals and Level 2 (less intensive-TFC entry level) referrals. Youth classified as Level 1 (foster care) are generally not served in the continuum but by county office staff.
- Will continuum providers license and offer regular foster care? What about foster care homes licensed by the Department? **Some providers do this now. DHR homes would not be affected.**
- Can the Department refer a child/family to the continuum before the child is actually in custody (prevention vs. reunification)? **Prevention cases are usually handled through different programming and are not a part of the continuum process.**
- How will the Family Resource Service Centers be used to deliver pre and post placement services? Are there other providers with the capacity to do the same services as part of the continuum?
- Expected outcomes for the providers must be clearly defined. What results are being purchased? **DHR is purchasing permanency as the outcome. The work is in defining the timeframes and services attached to getting there.**
- Given the uniqueness and complexity of care standards surrounding certain services (e.g. drug rehab/detoxification, sexual perpetration, etc.), are there services that should be carved out of the continuum model and allowed to stand separately alone? **Note that drug rehab and detox programs are typically short-term and/or acute in-hospital; and at the end of that, a child could enter a continuum. We need to differentiate between those youth with sexual behaviors versus those who have been convicted.**

Other Discussion

Discussion evolved around effective models of delivery. It was noted that in Florida's system referral to the provider occurred at the point of a founded CAN report and that with departmental oversight, the provider offered all services necessary to reunify with family or achieve another permanency outcome. This led to further discussion on the need for a clear definition of the roles of the DHR worker and the provider. The comment was made that DHR was not wanting to hand off cases once CAN indicated, but DHR staff could be free to think more strategically of long-term outcomes if they were not dealing with crisis management on a day to day basis. Regardless, DHR needed to be part of the continuum. **(Florida is a totally privatized care state, and the State agency has a remote oversight role only. Florida should not be used as a model for continuums in Alabama.)**

Finally, it was noted that collaboration among providers in the continuum must be reduced to detailed program and fiscal delineation.

Work from the Cost Subgroup:

Intro: This conference call was to help determine what issues related to costs need to be addressed re CoC issues affecting provider agencies and the State of Alabama DHR. Callers were asked for their input on any concerns they have knowing these issues will be addressed in detail at a later date.

Points that need to be considered:

- Risk sharing between providers and DHR
- Service carve-outs
- Bundled funding vs. categorical funding
- How youth move within the continuum (flexibility of service delivery)
- System of reinforcing moving the child to permanency
- What structure will be in place for arbitrating differences/disagreements between providers & DHR?
- Ensuring that adequate time is provided for after-care services
- Will the CoC be a one size fits all youth or will levels of need/care be assigned at admission to the CoC (differential rates based on level of child)?
- How will costs not directly related to Medicaid Rehab services be covered for the providers?(tracking/management costs, i.e. no funding stream available for providers to capture the cost of tracking outcomes of the children placed – how will these be offset?)
- One rate vs. multiple rates for CoC entry point? How will you compare/evaluate continuum providers if all are not required to provide a full range of services?

Point of Clarity:

Currently costing is done differently – cost is based on specific categorical services; so in the continuum, with outcomes driving the payment, if the provider is responsible for achieving permanency for 60% of the kids, then there needs to be some control of movement allowed.

Discussions that followed (Ms. Ward's questions/answers italicized):

1. *Where are we going to put intensive care and mothers & infants within the continuum (or put them as outliers)?* J. L. added that if we are going to have kids entering the Psych Under 21 programs, they need different levels of care and funding then someone entering the continuum at a TFC level. There will be a big difference in outcomes, also. He currently sits on the Definitions Committee, and he and J. W. understood that services such as the Wilderness Program, services for sexual predators and aggressively acting-out kids and/or actively addicted and/or clients needing detoxification would be carved out.
2. *Do your agencies have many of those types of clients?* No.
3. J. W. asked if the CoC would be broadly defined to include both prevention and reunification efforts, or strictly a reunification to permanency continuum. *Susan saw it as more of 1 or 2 CoC's per region (based on size of the region) with in-home on up services – residential intensive would be carved out.*

So, J.W. asked if the continuum would include:

- Prevention
- Basic foster care
- Therapeutic foster care
- Basic residential
- Intensive residential
- Mothers and infants (or Independent Living Programs, ILP)
- Permanency planning
- Reunification

Susan said that programs such as Wilderness and intensive residential would be carved out as stand-alone services (easier to pay this way and these services wouldn't have to be in every region). There are several intensive care programs across the state, but those who are doing the best job would be given the referrals. Also, they will not plan to use shelters and assessment homes will be going away. Jim Loop asked what they plan to use instead. Contract out or use MATS? Susan said they don't want providers doing MATS (you can do your own within your own agency); however, state DHR and/or state DHR designees will be contracting this out so that whatever services are provided are the right services, defensible, and credible. (This was per CWLA's advice.) If that doesn't work then they might have assessment centers where no other programs have somewhere to funnel kids into.

4. J. L. said that outcomes and their importance drives the system – the more specific and detailed the outcomes required by the Department, then the movement of the kids needs to be the agency's responsibility. If not, then we fall back on the question of how can we be responsible for outcomes if we don't have any control over the movement of the kids? *Susan said that of course they can't give case management away, but listened to more explanation on this issue.* Jim explained as an example, they are not asking for monetary management; however, if they are required to achieve permanency for say 60% of the kids entering the continuum, then they would have to have some flexibility with management of the child's movement. Currently, the Department controls the child's movement by ISP (long lengths of stay cited as a deficit in the ASFA review), this is of

concern to providers. *Susan asked if having set ISP's every 6 months would work?* In a continuum, this would be way too long. The agency would need to have flexibility in moving the child up or down , then notifying the Department of their movement; not waiting for the Department to get everyone together to hold an ISP meeting and decide on each movement. As another example, if the entry point was in TFC, and the state reimburses the provider at $60/day for this child for 18 months, with the outcome being the child in permanency by the end of that period: the pressure would be on the provider to move the child as quickly as programmatically possible (if one rate/child) – as there is a cost benefit to the provider in moving to a less costly service venue and a cost penalty if the child remains in a more costly service too long. Everyone agreed the continuum structure needs to allow the agency to have the right to move the child up or down, then to notify the State (not to sign off on the child, just to notify that the child has been moved).

5. Another issue was that the agency is paid when the child enters the CoC, but as the child is moved to more intensive services (if necessary) the agency then begins to lose money accordingly. And if no time/funding is built into the system for after-care services (though outcomes would be required following the child's exiting of the continuum), this would also cause providers to lose money. Stabilization of the child and family is critical once the child moves home and services are still important at this time. Discussion occurred around how Tennessee handles this (four month aftercare allowed for each child in the continuum) Another factor is that once the child is moved home (or to another permanent setting), after 4 or 5 weeks, pressure may be on the state to move this child out of the continuum prematurely so other, more involved youth can enter…

6. What about incentives – will they be based on whether or not your met your outcomes for the year (with no cash bonus at termination)? Leveling it out so you're not losing your shirt on the front end was discussed.

7. What are the budget assumptions for the State? Serve more people, cost neutral or cost savings? *Costs will certainly be more to start with, savings would be hoped for in the long run (depending a lot on how the MAT does on TFC and on recruitment (big if money saved on TFC).*

8. Are there any TANF dollars or Title IV dollars? *There are none (and if Medicaid Rehab goes, there will be no CoC).*

9. For those with collaborative agreements with other agencies, how will the model work invoicing-wise? *As a formal business relationship (i.e. formal agreements will be necessary).* Jim added that it would be important that member agencies are held accountable for their outcomes and their own expense – they can't bankrupt the lead agency. *Susan did not feel that the Department would get involved with the internal agency agreements.*

Before closing the conference call, Susan was asked what issues she would like to see for her and Gary Mitchell to review prior to the CWLA conference:

- What is necessary for a formal collaborative relationship? How involved does the Department need to be?
- Which services need to be carved out of the continuum?
- The ability for agencies to move the child within the continuum (flexibility to move the child up or down—start working at a breakeven and ability to write that into the initial ISP so not needed every time).

Final questions/thoughts by the providers:

- Should the CoC be a full array of services, residential CoC, in-home for reunification, or both reunification and prevention?
- The risks and liabilities of placing children in state foster care homes that providers have not licensed, etc., and the formal business relationship with DHR and how they are reimbursed. Can the foster care system be privatized? *Susan said this was a good question that has no answer yet.*

There are many other questions that need to be discussed and answered around cost issues that were not addressed due to time constraints. These were addressed in earlier emails and should be made part of subsequent discussions.

Work from the Barriers Subgroup:

BARRIERS & RECOMMENDATIONS:

1. Outside Entities: Court and education officials lack understanding of and agreement with step-down and/or return to home. Courts may want children to remain in foster care or at certain level of foster care and some school systems do not want children to return to their system. Multi-Needs is a big issue in some counties; DHR has the responsibility to provide services when abuse/neglect has never been an issue, particularly 19-21 year olds.

   Recommendations:

   - Educate GALs, JPO, Judges, DHR attorneys, and local school system about continuums.
   - Educate the community that families need to be together
   - Seek continued support from State Education re: movement of children to less restrictive environments (Barry Blackwell of State Education has sent worked with us in the past).
   - Seek ways to improve the policy/law re: Multi-Needs so that all agencies have equal responsibility and so that the appropriate agency is the lead agency (when child's behavior, not safety in the home is the issue).

2. Outcome Measures: Other systems have either failed to clearly establish outcome measures or to monitor the outcomes and providers have not received credit for good work. Tendency to look at quantity; it is more difficult to measure quality. Providers lack the authority to move children down (they may be measured on items over which they have no control).

   The Utilization Review Advisory Group is addressing this area.

3. Commitment/trust: There needs to be a buy-in by line staff; turf issues could be a barrier; there is disagreement re: child's placement needs (especially level of care needed or family's readiness for child to return home). What is required to return home or to a less restrictive environment is varied.

   Recommendation:
   - Involve veteran line staff in work groups – let them be a part of the process
   - Keep focus on the children and families
   - Have a kick-off that will involve different agencies and get everyone eager to begin the change
   - SDHR work with county to learn how to identify specific goals and outcomes and what is needed to close case
   - Establish a mediation process
   - Get all 67 counties on same page

4. Communication: There is not always clear, complete communication regarding the child's needs (some information isn't know at the time of initial referral – assessment is an ongoing process and new information may come to light at any time). Sometimes ISPs are either not shared with the provider or are they do not reflect what the provider understood would be in the ISP.

   Recommendation:
   - Develop method and timelines for direct communication between county and provider so that new information is shared with others in a timely manner
   - Have good initial assessment on child and family and ensure that all involved are conversant in all elements of assessing **Consider how the MAT will figure into this process—e.g. front-end initial assessment, step-down assessment, etc.)**

5. Availability of services: There may be different types of continuum and different levels.

   Recommendation:
   - Will need to develop policies and procedure that are flexible enough to take into account the different levels needed but structured enough to establish expected outcomes & roles. **Remember to keep the focus on permanency as the expected outcome.**

6. Varied expectations re: roles of provider and authorizing entity. Issue of no/reject, no/eject policy

   Recommendation:
   - Clearly define the roles of providers (suggestions are that they are in a supportive role, will provide the services, are an arm of the DHR worker) and the DHR staff (suggestions are that they are the case manager, they prepare the families to work with the provider and monitor the services, they are responsible for ensuring the families get what they need, and they are responsible for defining what must be in place for the child to return home or to a less restrictive environment).

- Establish clear definitions re: appropriate referrals for each level of care. Have clear understanding of what is expected of a continuum and what services are available in a continuum to provide for a better match with individual children.

Work from the Collaborative Subgroup:

We defined collaboration as: Agencies working together in a Continuum by providing a comprehensive array of services *to help youth in care achieve timely permanence.*

Potential Barriers Identified:

- Financial Issues
- Identifying a Lead Agency
- Turf Issues
- Policy Conflicts
- ISP Process (also a current barrier to best practice)
- Providers and DHR not working collaboratively together from the Point of Intake (Timeliness of Providers involvement in cases) (also a current barrier to best practice)
- Permanency Plans (also a current barrier to best practice)
- Lack of Involvement of Providers in Decision Making
- Case Management Responsibility- (Lack of Authority or Shared Authority)- Providers not having the authority to move youth through a Continuum
- Clearly Defined Expectations

Suggestions to Overcome Barriers

- Incentives
- Conflict Resolution (Independent Mediator)

Strengths:

- Reduce duplication of Services
- Improve Coordination/Delivery of Services
- May Change focus of System of Care
- Agencies from different disciplines working together toward a common goal
- Increases levels of Expertise and Specialization
- Lead Agency has responsibility of moving youth through a continuum
- One Social Worker/Case Manager assigned to child
- Services follow the Child
- Enhances the Ability to bring creativity to the System of Care
- Focus on strengthening the whole family as opposed to being focused on one child

These notes are just the beginning of discussion points that must be fleshed out as we begin in-depth planning for the issuance of an RFP for Continuum Services in the spring of 2006. The issues, barriers and recommendations will be used by other stakeholders as a spring-board for the development of a system that will revolutionize service delivery to the children and families for

whom DHR has joint planning responsibility. Continuums should be the catalyst in more quickly achieving permanency for children and for helping maintain children in their own homes, where intensive services can be provided to assure safety and well-being.

GM